Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DEL SOL MEDICAL CENTER
10030 N MACARTHUR BLVD
IRVING TX 75063

Carrier's Austin Representative Box
Box Number 19

MFDR Received Date
JANUARY 28, 2013

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-13-1335-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: Services denied at time authorization was requested. Patient was walk-in with a wound infection who was immediately admitted to surgery. Appeal request for retro-authorization also denied. Authorization was obtained for rehab services following surgery."

Amount in Dispute: $81,709.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute involves reimbursement for an inpatient admission. An inpatient admission requires preauthorization. Reimbursement in the present case has been denied because, according to the EOB's attached to request for medical dispute resolution, the 'services were denied at the time authorization/precertification was requested.' Because preauthorization was required, but not obtained, no reimbursement is due. The requestor has not established that any type of emergency situation existed such that preauthorization was not required. As such, no reimbursement is due."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2012 through November 16, 2012	Inpatient Hospitalization	$81,709.15	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the procedures for obtaining preauthorization for certain health care services.

3. 28 Texas Administrative Code §133.2 sets out the procedures for general rules for medical billing and processing definitions.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 39 – Services denied at the time authorization/recertification was requested.
   - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Did the requestor receive preauthorization for the inpatient hospital services?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(c)(1) the insurance carrier is liable for all reasonable and necessary medical costs relating to healthcare listed in subsection (p) or (q) of this section only when the following situations occur: (A) an emergency, as defined in Chapter 133 of this title; (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care. 28 Texas Administrative Code §134.600(p)(1) requires inpatient hospital admissions, including the principal scheduled procedures and the length of stay obtain preauthorization. The requestor states in their position summary that "services denied at time authorization was requested." The requestor has not submitted documentation to support the services were emergent in accordance with 28 Texas Administrative Code §133.2(a)(4)(A) which defines "a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part…"
2. Review of the submitted documentation finds that preauthorization was not obtained for these services; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 3, 2013 Date

Signature	Medical Fee Dispute Resolution Manager	October 3, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.